Avera Medical Group Pierre

A Department of Avera St. Mary's Hospital

Patient Information

Please give your insurance card(s) to the receptionist.

Legal name: _____ (Last) _____ (First) _____ (Middle)

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email: _____

Birth date: _____ Sex: M F Marital status: Married Single Divorced Widowed

Race: (Circle)
African American
Asian
Caucasian
American Indian, Alaska native
Native Hawaiian, Other Pacific Islander
Unknown
Declined

Ethnicity (Circle):
Hispanic or Latino
Non Hispanic or Latino
Declined

Preferred language (Circle):
English
Spanish
Other: _____

Social Security Number: _____ Employer: _____

Employer phone: _____ Occupation: _____

Responsible Party

Please complete if patient is a minor (Under 18 years old).

Legal name: _____ (Last) _____ (First) _____ (Middle)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Home phone: _____ Cell phone: _____

Email address: _____

Social Security Number: _____ Employer: _____

Employer phone: _____ Occupation: _____

Emergency Contact/Financial Release/Medical Release

I, _____, give the doctors and staff of Avera Medical Group Pierre, permission to release information to the people listed below:

(Please circle response under each column)	*Contact in case of emergency*		*Release medical information*		*Release financial information*	
Name: _____	Yes	No	Yes	No	Yes	No
Relationship to Patient: _____						
Phone: _____						
Name: _____	Yes	No	Yes	No	Yes	No
Relationship to Patient: _____						
Phone: _____						
Name: _____	Yes	No	Yes	No	Yes	No
Relationship to Patient: _____						
Phone: _____						

This information is true to the best of my knowledge. I understand that I am fully responsible for payment of all services received. I authorize Avera Medical Group Pierre, or any insurance company, to release all information required to process my claims.

_____

Patient/Guardian Signature *Date*